DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-14-26
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations
Disabled and Elderly Health Programs Group
Division of Integrated Health Systems

March 1, 2002

Mr. Dennis Braddock
Secretary
Department of Social and Health Services
P.O. Box 45010
Olympia, Washington 98504-5010

Dear Mr. Braddock:

I am pleased to inform you that the Centers for Medicare & Medicaid Services (CMS) is approving Washington's request for a 2-year continuation of its Integrated Community Mental Health Program authorized under section 1915(b) of the Social Security Act (the Act). This approval provides for waiver of the following sections of the Act: 1902(a)(1) Statewideness; 1902(a)(10)(B) Comparability of Services; 1902(a)(23) Freedom of Choice and; 1902(a)(30) Basis of Payment.

Sole source contracting has been a topic of continuing discussion with regard to this waiver. The CMS continues to review the Federal regulations at 45 CFR Part 74 and policies related to the open procurement process for Medicaid contracts. New policy or regulations may be issued, and if so, CMS would reevaluate the Medicaid contracting process for the Integrated Mental Health Services Program in Washington, prospectively, in light of the changes.

Following extensive collaboration and discussion with the Washington State Mental Health Division (MHD), CMS continues to be concerned that challenges exist within the Washington State mental health program that could impair Medicaid beneficiaries' access to the quality mental health services to which they are entitled. Therefore, CMS will continue to work with the State to address these issues via ongoing monitoring, the Terms and Conditions in this approval letter and the recommendations generated from CMS October 2001 statewide mental health program review.

This waiver approval is contingent on the conditions listed below; a timeline for deliverable items is included as an attachment. In addition to meeting the following conditions throughout the waiver period, the State will be responsible for documenting the cost-effectiveness, access and quality of care in subsequent renewal requests:

1) Enrollee Brochures/Information. A) The State will develop and implement an improved process for consistently evaluating all marketing materials (e.g., client brochures) submitted by RSNs to the State for review and approval. A description of this process will be submitted to CMS no later than September 30, 2002. B) The State will ensure that RSN client brochures are revised to include the information required by State standards and federal enrollee information requirements. Copies of these revised RSN brochures will be submitted to the CMS Regional Office (RO) no later than September 30, 2003. C) The State will submit to CMS upon completion the initial notification of Medicaid eligibility information to be included in beneficiary eligibility packets sent by the State.

2) Data. The State will submit data reflecting the unduplicated number of individuals served by each RSN. Data are to include the number served in 2002 and projected number to be served for 2003. Data will be reported by RSN, and include both the number and percentage of the total served that are Medicaid vs. non-Medicaid. Data must be comparable (e.g., the same definitions or methods of identifying and counting individuals) to that submitted in the State's response to the CMS Request for Additional Information dated September 10, 2001. These data are to be submitted to the CMS RO no later than September 30, 2003.

3) Reports. Upon completion, the State will submit to the CMS RO copies of all reports generated by the QA and I Team as a result of their annual on-site reviews of RSNs.

4) Access to Services. The State will develop and implement a standard set of criteria, and a standard set of methods of implementation, to be used statewide in all RSNs for screening, assessment and authorization of services. Criteria and methods for implementation must assure that all Medicaid eligible individuals in need of mental health services have access to needed services. Access to services must be based on clinical criteria and may not be prioritized based on the degree of severity or acuity. A) The State's plan to effect this change must be submitted to the CMS RO by November 30, 2002. B) Evidence of progress toward this change, including the pursuit of any necessary State statute revisions, will be provided to the CMS RO by November 30, 2003.

5) Actuarial Soundness of Rates. The State will provide for actuarial review of rates calculated to satisfy the cost effectiveness determination and submit a report from that study to the CMS RO by November 30, 2002. The report from this study must be based on the most recent year's service data collected from the RSNs and include specifics about: a) the individuals included in/excluded from the calculations (category and number in each category); b) categories or types of services provided; c) a reasonable projection of costs of services if reimbursed under fee-for-service; d) all assumptions built into the calculations (e.g., the number of eligibles likely to need

services); e) any adjustments or trending factors applied to the data; f) all definitions relevant to categories and types of populations and services; and g) a capitated rate(s) based on these data.

6) Enrollee Protections: Access. The State will develop and implement a process to more comprehensively monitor RSN and MHC activities to ensure that enrollees have adequate access to required protections. This process will include, at a minimum: a plan to assure that procedures for written notification of denial of services are followed; a plan to increase awareness and understanding of the disenrollment process throughout all levels of the system in all RSNs, as well as indicators through which the State can provide assurance that the process has been implemented effectively; and a plan to increase awareness and understanding of the Fair Hearing process throughout all levels of the system in all RSNs, as well as indicators through which the State can provide assurance that the plan has been implemented effectively. A) The plan for implementing all three components must be submitted to CMS by September 30, 2002. B) A report of the State's activities to monitor progress of their plan(s) must be submitted to the CMS RO by September 30, 2003. C) To allow adequate time for implementation and monitoring, results of the State's activities to monitor effectiveness of their plans will be submitted to the CMS RO prior to December 31, 2004.

7) Enrollee Protections: Contract Termination. A) The State will provide a description of enrollee protections in place in the case that an RSN would withdraw from its contract with the State or the State would terminate an RSN provider contract in the case of non-compliance or poor contract performance (which include termination in the case of service delivery or quality of care issues). B) The State will also provide a plan to describe: those protections in place to ensure continuity of care for enrollees, transitioning medical records and other necessary information to the new contractor/provider; and provisions for management functions necessary for the continuance of service delivery. This description may include provisions that appear in provider contracts. These items will be submitted to CMS within 90 days of the date of this waiver renewal approval.

8) Children with Special Health Care Needs. The State will continue to gather information regarding children with special health care needs (as defined in the Balanced Budget Act of 1997) according to the same data gathering methodology and categories as tracked and submitted to CMS in the past waiver renewal period. The State will submit to CMS similar reports (e.g., enrollment, grievances, appeals, disenrollment requests) on an annual basis. The State will also continue to submit annual information regarding geographic distribution and analysis of the network capacity as it relates to PCPs and specialists who are experienced providers with this population. The State's compilation and analysis of these data will be submitted to CMS before September 30, in each year of the renewal period.

Approval of this waiver renewal covers a period of 2 years, from March 5, 2002, through March 4, 2004. Washington State officials may request that this authority be renewed and should submit its request for renewal 90 to 120 days in advance of the waiver expiration date.

We appreciate the State's efforts in continuing this program designed to provide accessible, quality and cost-effective health care for Medicaid enrollees.

Sincerely,

/s/

Theresa A. Pratt
Director

Enclosure
cc:
Karen O'Connor, Acting Chief, Medicaid Branch, Region X
Karl Brimner, Mental Health Division

Washington Integrated Community Mental Health Services Terms and Conditions Deliverables Timeline

T&C #	Deliverable	Date
7	Enrollee Protections: Contract Termination Plan	90 days post-approval
1C	Enrollee Brochures/Information: Notification of Medicaid Eligibility	Upon Completion
3	Reports: QA and I-team reports	Upon completion
1A	Enrollee Brochures/Information: Standard Review Process	September 30, 2002
6A	Enrollee Protections: Access: Monitoring Plan	September 30, 2002
8	Children with Special Health Care Needs Reports for First Year	September 30, 2002
5	Actuarial Soundness of Rates Report	November 30, 2002
4A	Access to Services: Plan	November 30, 2002
1B	Enrollee Brochures/Information: Revised Brochures	September 30, 2003
2	Data: Utilization Information	September 30, 2003
8	Children with Special Health Care Needs Reports for Second Year	September 30, 2003
6B	Enrollee Protections: Access: Report of State Activities	September 30, 2003
4B	Access to Services: Evidence of Progress	November 30, 2003
6C	Enrollee Protections: Access: Results of Monitoring	December 31, 2004